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HEALTHCAREMANAGEMENTPROFESSIONALS

January 20, 2000

U. S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Attention: Privacy-P
Room G-322A Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D. C. 20201

Re: 45 CFR, Pans 160 through 164: Standards for Privacy of Individually Identifiable Health Information

Dear Sirs:

The American Health Information Management Association (AHIMA) appreciates the opportunity to comment on the notice of proposed rule-making regarding standards for privacy of individually identifiable health information. AHIMA commends the Department of Health and Human Services (DHHS) on the provisions of the proposed rule.

AHIMA is committed to the enactment of comprehensive federal legislation to protect the confidentiality of health information. The current legal obligation of healthcare providers to maintain the confidentiality of health information is based on what the Office of Technology Assessment found to be a patchwork quilt of federal and state laws. AHIMA is disappointed that Congress did not pass comprehensive legislation by its August 21, 1999 self-imposed deadline. However, we commend DHHS for proposing standards consistent with the administrative simplification provisions of the *Health Insurance Portability and Accountability Act of1996 (HIPAA)*. It is important to note that the proposed rule recognizes that "A clear and consistent set of privacy standards would improve the effectiveness and efficiency of the health care system."

AHIMA has consistently endorsed the following health information confidentiality principles, most of which are expressly addressed in the NPRM:

AHIMA Confidentiality Principles	HHS' Proposed Privacy Standards
Preemption-Federal efforts must preempt state laws and regulations to create a single national standard for treating and handling health information.	*160.203. HIPAA provides that the rule promulgated by the Secretary may not preempt state laws that are in conflict with the regulatory requirements AND that provide greater privacy protections.*
Patient's Right to Know-Each patient, directly or through a representative, must have the right to know by whom and for what purpose his or her healthcare information is maintained.	*164.512. Establishes that an individual has a right to adequate notice of the policies and procedures of a covered entity that is a health plan or a health care provider with respect to protected health information.*
Minimum necessary-A collection of health information should be restricted to only the extent necessary to carry out the legitimate purpose for which it was collected.	*164.506. Provides that a covered entity must make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intendedpurpose of the use or disclosure.*

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AHIMA Confidentiality Principles	HHS' Proposed Privacy Standards
Restrictions on Collection-Individual healthcare information must be collected only for legitimate purposes, such as medical research, enhancing public health, and combating fraud. Use of Information-Healthcare information must be used only for necessary and lawful purposes. **Restriction**—Healthcare information must not be used for purposes other than for those for which it is collected, except as provided by law.	*164.506. Establishes that a covered entity may not use or disclose on individual's protected health information, except as otherwise permitted or required by this port or as required to comply with applicable requirements of this subchapter* (164.506)
Notification—Any entity maintaining healthcare information must prepare and make available to patients upon request a written statement outlining its information practices.	*164.512. Establishes that an individual has a right to adequate notice of the policies and procedures of a covered entity with respect to protected health information. Provides that a notice of information practices be provided to individuals upon request AND establishes specific requirements for health plans and health care providers.*
Patient Access-Each patient, directly or through a representative must have access to his or her healthcare information and the right to copy, amend, and or correct it.	*164.514. Establishes that an individual has a right of access to, which includes a right to inspect and obtain a copy of; his or her protected health information in designated record sets of a covered entity, including such information in a business partner's designated record set that is not a duplicate of the information held by the provider or plan. for so long as the information is maintained.* *164.516. Establishes that on individual has a right to request a covered entity to amend or correct protected health information about him or her in designated record sets of the covered entity for as long as the covered entity maintains the information.*
Safeguards—Any entity maintaining individually identifiable healthcare information must be required to implement reasonable security safeguards.	***164.518(c). A covered entity must have in place appropriate** administrative, technical and physical **safeguards** to protect the **privacy** of protected **health information.*** *Will also be addressed **by the proposed rule for Security and Electronic Signature Standards published on August 11, 1999.***

AHIMA Confidentiality Principles	HHS' Proposed Privacy Standards
Penalties—Both criminal and civil penalties must be provided for persons who violate privacy laws and regulations.	*Addressed by summary and purpose. Recommends federal legislation to include punishment for those who misuse personal health information and redress for people who are harmed by its misuse. Criminal and civil penalties are supported.*

Our comments are intended to help strengthen the proposed rule and increase it's consistency with the intent of ***HIPAA's*** administrative simplification provisions.

APPLICABILITY

AHIMA recommends that the scope of the rule be extended to include all individually identifiable health information, including purely paper records, maintained by covered entities. AHIMA will support legislation to expand the scope of this regulation.

Under the proposed rule, health information management professionals will be required to manage paper and electronic record systems differently. This will be a difficult and costly requirement at best and administratively impossible at worst. Electronic health records should not be afforded greater privacy protections than records maintained on paper. It is the information content that is to be protected, not its storage medium. Information should be protected by standards that are technologically neutral -- standards that are strict and will protect health information in a changing technological environment.

Further, this distinction does not serve the needs of the patients who are not likely to understand why electronic records are held to a different standard. Patients should not have to determine the electronic or non-electronic status of their health record to understand their rights and to be assured their health records are protected.

The intent of the administrative simplification standards of ***HIPAA*** is to "improve...the efficiency and effectiveness of the health care system, by encouraging tbe development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." By establishing standards for electronic and electronically transmitted information only, AHIMA fears that this proposed rule may not meet the intent of HIPAA and also inadvertently act as a disincentive for entities to migrate to electronic record systems.

AHIMA also believes that the disparate standards for electronic and electronically transmitted data may encourage the creation of "shadow" health records. We discuss "shadow" records more thoroughly in our comments on the defmition of "psychotherapy notes."

160.103 AND 160.504 **DEFINITIONS**

Health Care Operations-AHIMA recommends that the words "risk reduction activities" be added to the definition of "health care operations" under subpart I or 5.

We recommend the expansion of the defmition of "health care operations" to explicitly cover those activities associated with incident (adverse occurrence) reporting, investigation, and follow-up. Risk managers carry out processes designed to prevent situations that could give rise to patient care accidents. Not all of these activities can be classified as either "quality assessment and improvement" or "in anticipation of or for use in legal proceedings", although risk managers are indeed involved in both of these activities. For example, most of the incidents which risk managers investigate are never expected to result in litigation, and they may not fall within the boundaries of the organization's quality improvement efforts.

A narrow reading of this defmition might make those incident reports and investigations available to the patient who is the subject matter, and such a reading would lead to regular court challenges seeking such incident reports. It does not appear to be the Secretary's intent to make this information available, as it would likely have a chilling effect on incident reporting programs, which do contribute to improvements in patient care. By explicitly mentioning "risk reduction activities, such as incident reporting and investigation" in Section 164.504's defmition of "health care operations," under number (5), "Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding," we believe the Secretary's intent to exempt this information from disclosure would be made more clear.

Individual—Disclosures pursuant to power of attorney. AHIMA requests further clarification on "the person informally designated as the patient's healthcare decision maker."

It is not clear what is meant by "the person informally designated as the patient's healthcare decision maker." More guidance is needed on this issue. When reference is made regarding healthcare decisions, consistent reference should be made to the healthcare power of attorney. The explanatory information concerning "informal designation" of a patient's healthcare decision-maker is inconsistent with current practices. We believe this could place the healthcare provider in the middle of family disagreements about who should be the "healthcare decision-maker."

It is unclear as to what sort of "informal designation" would be sufficient. Does accompanying a patient on an office visit qualify an individual as an informal "healthcare decision-maker? Is it enough that if they are in the hospital room when the doctor discusses options with the patient? Although this course seems well intentioned and undoubtedly is intended to enable providers to more openly discuss patient details with family members and significant others, we see a great potential for misunderstandings and conflict.

AHIMA believes that on the occasion that a person chooses to share decision-making about a particular treatment episode with another party, this should not result in a wholesale abandonment of their right to control the flow of information to that party.

AHIMA recommends amending the definition of psychotherapy notes to ensure their appropriate inclusion in the medical record. AHIMA recommends that the definition recognize a distinction between psychotherapy notes and the case notations maintained by the therapist.

The proposed definition of psychotherapy notes varies from actual clinical practice. Reports of psychotherapy are part of the medical record. While therapists may maintain separate notations of therapy sessions for their own purpose: this does not preclude the need to summarize psychotherapy in the medical record.

The proposed defmition may encourage the creation of "shadow" records, entries by therapists apart from the official medical record. The creation and existence of such records may be dangerous to the patient and may increase liability for the health care providers if, for example, the patient requires emergency treatment. For example, a patient may be delivered to an emergency department in an unconscious state and require immediate treatment. If a "shadow" file exists that contains critical health information, the existence of such a tile will most likely not be known by anyone other than the provider who created the file. If the creating provider is unreachable or overzealous in sequestering the data, tbe emergency provider will not be privy to all necessary information to treat the patient. Therefore, the emergency provider's treatment decisions may cause irreparable harm to the patient. Further, "shadow" records increase costs and confound accountability.

164.506 INTRODUCTION TO GENERAL RULES

AHIMA recommends treating all health information equally, regardless of its type.

Because the misuse of any individually identifiable health information is potentially destructive to the health and well-being of patients-sometimes leading to discrimination in employment, insurance, and healthcare-AHIMA strongly believes that all health information must be protected equally. As destructive as the unauthorized dissemination of, for example, genetic, psychiatric, or HIV/AIDS information, so too may be the unauthorized dissemination of information regarding chronic conditions, such as heart disease or cancer. Restricting the legitimate use of any type of individual health information, however, could impede the quality of care and thwart one of the principle purposes for which it is gathered-research in pursuit of more effective cures.

AHIMA believes that segregating and creating special categories of healthcare information ultimately would be more dangerous than beneficial. The current patchwork of at least 50 different sets of standards impedes our ability to protect confidentiality. Additionally, special requirements for handling certain types of information-such as genetic information and mental health information-actually may be counterproductive to privacy. Special requirements both stigmatize the information and can give away the information's type. For example, when the requirement existed for healthcare professionals to wear latex gloves when working with HIV/AIDS patients, just treating the patient was enough to announce the condition. When the policy changed requiring the wearing of latex to treat all patients, the conditions, in most cases, became invisible.

Establishing a single national standard will protect information and help healthcare providers and patients better understand and manage the flow of health information.

164.506(B) MINIMUM NECESSARY USE AND DISCLOSURE

AHIMA supports the concept of "'minimum necessary use and disclosure." However, AHIMA urges the DHHS to establish a "good faith" standard for covered entities who disclose the information with a statement that prohibits the use of the information for other than the stated purpose and requires destruction of the information after the stored need has been fulfilled. AHIMA further recommends thnt covered entities be deemed in compliance with the "'minimum necessary use and disclosure" standard with regard to internal uses and disclosures if their computer-basedpatient record (CPR) systems use the appropriate safeguard mechanisms and meet the forthcoming security requirements.

The concept of "minimum necessary use and disclosure" is one of AHIMA's principles for health information confidentiality. Even so, as the proposed standard is currently drafted, the requirement that a covered entity make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure will be impracticable to manage. The definition of minimum amount is highly subjective and there is no clear guidance or bright line test to provide guidance to covered entities. Therefore, alternative means to meet this standard must be devised.

Establishing a "good faith" standard for covered entities is an approach that would require the covered entity to decide what reasonably meets the needs of the requestor of the information. In AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information (Attachment* I) , AHIMA recommends the following:

> ". .That the responsibility for disclosure of health information be centralized under the direction of the provider's health information management professional to ensure compliance with legal requirements and the provider's policies for disclosure. Only a few qualified individuals should be authorized to disclose health information, and they should be carefully trained and supervised."

AHIMA further recommends that:

> "A statement that prohibits use of the information for other than the stated purpose and requires destruction of the information after the stated need has been fulfilled, should accompany any disclosure of health information to external requestors."

The following health information management manuals have been attached to assist DHHS in developing clear guidance for the minimum necessary standard:

1. *Release and Disclosure: Guidelines Regarding Maintenance ond Disclosure of Health Information*
2. *HIV and Confidentiality: Guidelines for Managing Health Information Relating to HIV Infection*
3. *Faxing Safeguards: Guidelines for Transmitting Patient Health Information*
4. *Security and Access: Guidelines for Managing Electronic Patient Information*

In most instances, the knowledge of confidentiality procedures and the qualifications of the requestor of the information are not known. Therefore, for the "minimum standard" requirement to work, we believe the ultimate decisions must be made by those who have been adequately trained and educated in release and disclosure requirements. Health information management professionals are prepared by education and experience to make such important determinations.

Covered entities should be deemed in compliance with the "minimum necessary use and disclosure" standard with regard to internal uses and disclosures if their computer-based patient record (CPR) systems use the appropriate safeguard mechanisms and meet the forthcoming security requirements. This will encourage covered entities to fully utilize the security capabilities offered by a CPR. AHIMA strongly supports the migration of patient records to the electronic environment. As opposed to paper-based record systems, CPR systems can more readily limit who has access to information, determine what information to disclose depending on the request, and track the flow of the information. These functions are critical to provide privacy and security for individually identifiable health information.

164.506(c) RIGHT OF AN INDIVIDUAL TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES

AHIMA recommends deleting the proposed standard "Right of an individual to request restriction on uses and disclosures."

AHIMA does not support the concept that individuals be able to request that a covered entity restrict the protected health information that results from a" encounter from further use or disclosure for treatment, payment and healthcare operations. Since covered entitles would not be required to agree to restrictions requested by individuals, this proposal appears meaningless.

While we believe individuals should have the right to access, copy, amend, and correct their information, giving them the right to request restricting its uses and disclosures is in contrast with the intent of the proposed rule. When addressing the need for privacy standards, the proposed rule states:

> "The maintenance and exchange of individually identifiable health information is a" integral component of the delivery of quality health care. I" order to receive accurate and reliable diagnosis and treatment, patients must provide health care professionals with accurate, detailed information about their personal health, behavior and other aspects of their lives. Health care providers, health plans and health care clearinghouses also rely on the provision of such information to accurately and promptly process claims for payment and for other administrative functions that directly affect a patient's ability to receive needed care, the quality of that care, and the efficiency with which it is delivered."

Permitting patients to dictate the flow of their health information for treatment, payment and health care operations will seriously hamper the ability to achieve the intentions stated above. The lack of complete

and accurate information will only hinder the ability to provide quality care, process claims, and complete other necessary and beneficial administrative functions.

164.506 (D) CREATION OF DE-IDENTIFIED INFORMATION

AHIMA supports this concept but requests further clarification on removing information from the body of the medical record that may indirectly identify the individual. AHIMA recommends the DHHS establish a "'good faith" standard for covered entities who make reasonable efforts to de-identify information when required Additionally, we recommend that the receiver of the de-identified information be required to sign an agreement not to re-identify or link the information to the individual(s) to whom it pertains. AHIMA believes that the proposed rule should make it a violation to attempt to re-identify or re-link the previously de-identified information to the individual(s) to whom it pertains.

The proposed rule's intent to encourage the creation and use of de-identified information is positive. However, the list of 19 potential identifiers that must be removed from a record to create de-identified health information establishes a difficult standard as some identifiers may be buried in lengthy text fields. Nonetheless, this is a worthy standard and the migration to the CPR will greatly enhance compliance.

Establishing a "good faith" standard for covered entities is an approach that requires the covered entity to decide what reasonably can be removed from the patient's health information. As an additional precaution, AHIMA believes that a signed agreement between the covered entity and the receiver of the de-identified information would be an adequate deterrent, under the threat of violating the rule, to any attempts by the receiver to reidentify or link the information to the individual(s) to whom it pertains.

164.506(E) BUSINESS PARTNERS

AHIMA recommends that transcription services be specifically included as business partners

Outsourcing transcription services is a regular business practice of healthcare facilities. These services can be provided from an individual's home, a central business location, or even beyond the borders of the United States. No matter where transcription services are located they normally receive highly sensitive and identifiable health information creating jurisdictional and enforcement problems for state and federal agencies. Therefore, AHIMA recommends that transcription services be specifically included as business partners.

164.506(F) DECEASED PERSONS

AHIMA recommends that the privacy standards for deceased persons be the same as those for living persons.

AHIMA sees no compelling reason to set a different privacy standard for deceased individuals. It has been standard practice to release individually identifiable health information of deceased individuals with a valid consent of the executor, next of kin, or specific court order. We recommend that this practice be upheld in the regulations.

164.508 INDIVIDUAL AUTHORIZATION

AHIMA recommends that authorizations be required to specify on expiration date not to exceed one-year. AHIMA also recommends that the use of 'prospective" authorizations (authorizations signedprior to the treatment episode from which the information is requested) be prohibited In all cases, AHIMA recommends that it be a violation of the rule if the information is redisclosed beyond what was authorized by the patient or the patient's legal representative.

It is in the patient's and covered entity's best interest to tighten authorization practices. Our recommendations will stern the tide of unlimited and lengthy authorization requests for information; information that, in many cases, has not yet even been created. A valid authorization not to exceed one year offers the patient an opportunity to reevaluate and reauthorize the consent. The "any and all information" authorization has been abused and patients have been basically required to sign away the rights to their most personal information. Additionally, the use of prospective authorizations precludes intelligent decision-making on the part of the patient, as they are asked to authorize the release of the information that does not yet exist.

Further, protections against redisclosure of the information are necessary. As stated in AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information:*

> "When information from health records is provided to authorized external users, this information should be accompanied by a statement:
>
> - Prohibiting use of the information for other than the stated purpose;
> - Prohibiting disclosure by the recipient to any other party without written authorization from the patient, or the patient's legal representative, unless such information is urgently needed for the patient's continuing care or otherwise required by law; and
> - Requiring destruction of the information after the stated need has been fulfilled."

164.510(F) LAW ENFORCEMENT

AHIMA recommends that, except in the cases described in Section 164.510 (f)(2), Limited information for identifying purposes, a warrant, subpoena, or court order be required for the release of protected health information.

While the proposed requirements are an improvement over the Secretary's original recommendations to Congress, AHIMA does not believe that the requirements are restrictive enough. The proposed rule would substantially weaken current privacy practices with respect to access by law enforcement officers. Under the current language, all an officer needs to access health information on any citizen is simply to request that information and verify his own identity as a law enforcement employee. Health information management professionals across the United States have reported numerous conflicts with local, state, and federal law enforcement officials attempting to access an entire health record, when only very limited information is needed. Current practices at the State level generally require an officer or law enforcement employee to obtain a warrant, subpoena, or court order to obtain health information, and that requirement should be upheld. We would, however, support the limited disclosure of health information for use solely in identifying a suspect, fugitive, material witness, or missing person, under the requirements and qualifications outlined in the proposed rule. We feel this sties a reasonable balance in meeting the needs of law enforcement, while still protecting health information from inappropriate uses.

164.512 RIGHTS AND PROCEDURES FOR A WRITTEN NOTICE OF INFORMATION PRACTICES

AHIMA supports the requirement that any entity maintaining healthcare information must prepare and make available to patients upon request a written statement outlining its information practices and posting the notice in a clear and conspicuous manner. AHIMA does not support the idea of obtaining a signed acknowledgement from the individual upon the receipt of a notice of information practices.

In the proposed rule, 'DHHS requests comment regarding requiring a covered entity to obtain a signed acknowledgement by an individual. There are many covered entities for which it would not be practical or

enforceable. The administration of such a task would be overly burdensome and inconsistent with the intent of the administrative simplification requirements of HIPAA. Also, due to the number of patients who are incompetent or unconscious, it would not make sense to require that a signed acknowledgement be obtained.

164.514 ACCESS FOR INSPECTION OR COPYING

AHIMA supports the reasonable, cost-bused fee standard for copying health information pursuant to this section. In addition, AHIMA recommends that a covered entity bepermitted to charge a reasonable, cost-besedfeefor inspection of the record and be able to establish the procedures for the review process.

Depending on the size of the entity, copying and inspection costs could vary significantly. AHIMA recommends that the following factors be taken into consideration in determining the fee:

- Labor costs for verification of requests
- Labor and software costs for logging of requests
- Labor costs for retrieval
- Labor costs for copying
- Expense costs for copying
- Capital cost for copying
- Expense costs for mailing
- Postal costs for mailing
- Billing and bad-debt expenses
- Labor costs for refiling

164.515 ACCOUNTING OF DISCLOSURES

AHIMA does not support the proposed requirement that covered entities maintain an accounting of disclosures for as long as the entity maintains the protected health information. AHIMA recommends thot the accounting of disclosures of records be maintained for a period of six years.

Many covered entities maintain health information based on state record retention statutes and regulations. It would be impractical for covered entities to retain a" accounting of disclosure for as long as the entity maintains the protected health information. Maintaining an accounting of disclosure for a period of six years would be consistent with the record keeping requirements for authorization forms and contracts used with business partners as well as other documents specified in the rule.

164.516 **RIGHTS AND PROCEDURES FOR AMENDMENT AND CORRECTION**

AHIMA supports the proposed requirement that covered plans and providers be required to accommodate requests for amendment or correction for as long as the entity maintains the protected health information.

AHIMA believes that the proposed rule should not have a specific duration requirement for amending and correcting records. Individuals should be able to request amendments or corrections for as long as the covered entity maintains the protected health information. There are many instances in which individuals do not discover errors in their health information until years later when, for example, renewing a life insurance policy. It would set a bad precedent to deny a patient the ability to correct a health information error from years prior.

164.518(A) DESIGNATION OF A PRIVACY OFFICIAL

AHIMA supports the proposal that covered entities designate a privacy official. AHIMA strongly recommends thot the privacy official be a credentialed health information management professional.

In the proposed requirement, the privacy official is to "serve as the official responsible for the development of policies and procedures for the use and disclosure of health information." This describes the role that health information management professionals have traditionally held. Health information management professionals are qualified by education and experience to be privacy officials as they are educated and pass a certification examination that cover the 12 knowledge clusters shown in the attachment entitled "Curriculum Content for Health Information Administration" (attachment 5). This education includes legal, regulatory and voluntary standards concerning health record content, release, disclosure, confidentiality, and information management technology.

AHIMA commends the DHHS for highlighting the importance of this role.

164.518(B) TRAINING

AHIMA supports the concept of requiring recertification once every three years and retraining in the event of material changes in thepolicy.

As noted in the proposed rule, AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information* recommends the following:

> "That healthcare providers have their employees, students, and volunteers sign a nondisclosure agreement at the time of their employment or assignment. For employees who will have access to confidential information as part of their duties, signing the nondisclosure agreement should be required as a condition of employment. In addition, AHIMA recommends that each employee, student, or volunteer sign a nondisclosure acknowledgement on an annual basis to remind the individual of his or her ongoing responsibility."

AHIMA is willing to forego our recommended annual recertification acknowledgement and support the proposed rule's call for recertification once every three years.

AHIMA strongly supports the recommendation that providers educate and train their employees concerning privacy, confidentiality and security. Institutional policies and procedures should describe the responsibility of individual employees in maintaining confidentiality. as well as the consequences of unauthorized use or disclosure of individually identifiable health information.

RELATIONSHIP TO STATE LAWS

AHIMA continues to support federal preemptive legislation as a necessary ultimate solution. While recognizing the limitations of the HIPAA statute with respect to state lows and regulations, AHIMA recommends thot federal efforts must preempt state laws ond regulations to create a single national stondord for handling health information. AHIMA will continue to pursue health information confidentiality legislation that preempts state lows and regulations, treats all health information equally, ond establishes a strong, single, national standard for the use and disclosure of health information.

It has been argued by those who oppose a single national standard that states may have enacted a higher standard. However, in most cases, state laws and regulation address specific aspects of health information for example, mental health and home care. None has enacted a comprehensive and strong standard.

State boundaries are less and less relevant in regulating healthcare and health information management practices. With the growth of metropolitan areas crossing state lines, continental travel, multi-state

commuting, multi-state health systems, the Internet, national managed care plans, and other factors, our healthcare system is no longer a local resource. Health information crosses state lines and between facilities on a continuous basis.

Health information management professionals handle millions of pieces of health information each day. We understand that the legislative/regulatory actions of one state directly impact health information management practices in another. The only way to ensure that all health information is managed consistently and protected equally is by establishing a strong and uniform national standard with penalties for the wrongful disclosure of health information.

CONCLUSION

AHIMA and the nation's health information management professionals stand ready to support your efforts by working to effectively implement final regulations to improve the privacy of individually identifiable health information. Thank you for the opportunity to provide these comments.

Sincerely,

Charlene Kieffaber, RHIA
Health Information Management Consultant
Ryerson Management Associates, Inc.